

Patient Request for Health Information



PATIENT INFORMATION *(please print)*

PATIENT NAME (First, MI, Last)

NAME AT TIME OF TREATMENT (If different than above)

DATE OF BIRTH (MM/DD/YYYY)

PHONE

EMAIL (Optional)

STREET ADDRESS

CITY

STATE

ZIP

WHAT RECORDS DO YOU WANT? *(check appropriate boxes below)*

DATES OF SERVICE: _____ / _____ / _____ through _____ / _____ / _____

Office Visit Notes

Billing Records

Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

Other (Immunization Records, Medication List) Please specify: _____

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

Paper (no charge)

Home Delivery

In-Person Pickup

Electronic

CD (additional \$6.50)

Other (please specify): _____

WHERE DO YOU WANT THE INFORMATION SENT? *(complete appropriate boxes below)*

PrairieStar should provide my records to:

Self

Personal Representative (indicated below)

RECIPIENT NAME

PHONE

RECIPIENT EMAIL (if applicable)

FAX

RECIPIENT MAILING ADDRESS

CITY

STATE

ZIP

PATIENT SIGNATURE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

TIME

Please return completed form to:

PrairieStar Health Center
Health Information Management Department
2700 East 30th Ave.
Hutchinson, KS 67502

Email: HIMdepartment@praiiestarhealth.org
Fax: 620-663-9526
Phone: 620-663-8484

PrairieStar Health Center recognizes a patient's right under HIPAA to access copies of his/her health information.
There may be charges associated with processing a request and producing requested records.